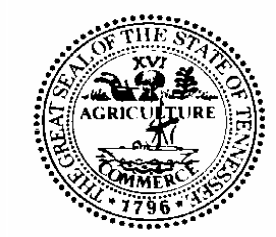

STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

MEMPHIS MANAGED CARE CORPORATION

MEMPHIS, TENNESSEE

FOR THE PERIOD JANUARY 1, 2005
THROUGH JUNE 30, 2005

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DEPARTMENT OF COMMERCE AND INSURANCE
TENNCARE DIVISION
500 JAMES ROBERTSON PARKWAY, SUITE 750
NASHVILLE, TENNESSEE 37243-1169

615-741-2677 **Phone**

615-532-8872 **Fax**

TO: J. D. Hickey, Deputy Commissioner
Tennessee Department of Finance and Administration, TennCare Bureau

Paula A. Flowers, Commissioner
Tennessee Department of Commerce and Insurance

VIA: Gregg Hawkins, CPA, Assistant Director
Office of the Comptroller of the Treasury
Division of State Audit

Lisa R. Jordan, CPA, Assistant Commissioner
Tennessee Department of Commerce and Insurance

John Mattingly, CPA, TennCare Examinations Director
Tennessee Department of Commerce and Insurance

CC: Dave Goetz, Commissioner
Tennessee Department of Finance and Administration

FROM: Paul Lamb, CPA, TennCare Examinations Manager
Shirlyn W. Johnson, CPA, TennCare Examiner
Malinda Stanford, CPA, TennCare Examiner
Karen Degges, Legislative Auditor

DATE: March 24, 2006

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Memphis Managed Care Corporation, Memphis, Tennessee, was completed October 13, 2005. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of Memphis Managed Care Corporation (MMCC). Further, this report reflects the results of a limited scope examination of financial statement account balances as reported by MMCC. This report also reflects the results of a compliance examination of MMCC's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of MMCC was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) between the State of Tennessee and MMCC, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-215 and § 56-32-232.

MMCC is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of MMCC. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statement as reported by MMCC on its National Association of Insurance Commissioners (NAIC) quarterly statement for the period ended June 30, 2005, and the Medical Fund Target Report filed by MMCC as of June 30, 2005.

The limited scope compliance examination focused on MMCC's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements and the Insurance Holding Company Act.

Fieldwork was performed using records provided by MMCC before and during the onsite examination of records from September 28 through October 13, 2005.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that MMCC's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations, thus reasonably assuring that the MMCC TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether MMCC met certain contractual obligations under the CRA and whether MMCC was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq*.;

- Determine whether MMCC had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether MMCC properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether MMCC had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether MMCC had corrected deficiencies outlined in prior examinations of MMCC conducted by TDCI.

III. PROFILE

A. Administrative Organization

MMCC was organized as a not-for-profit corporation by its sole members, Shelby County Health Care Corporation d/b/a The Regional Medical Center at Memphis (The MED) and UT Medical Group, Inc. (UTMG). MMCC was initially organized to provide for the delivery of health care services to members of the State's TennCare Program and has participated in the program since its inception on January 1, 1994. MMCC was incorporated on July 7, 1993, and was licensed as an HMO with the state on November 24, 1993.

The officers and board of directors for MMCC at June 30, 2005, were as follows:

Officers for MMCC

Al King, President
Bruce Steinhauer, MD, Secretary

Board of Directors for MMCC

Steven Burchett	Stuart Polly, MD
Jeff Brandon	Bruce Steinhauer, MD
Al King	Brenda Jeter
Andy Spooner, MD	Dennis Schaberg, MD
Barry Fowler	

B. Brief Overview

Effective May 1, 2002, the CRA with MMCC was amended for MMCC to temporarily operate under a non-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. MMCC agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization, MMCC receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to MMCC. The TennCare Bureau reimburses MMCC for the cost of providing covered services to TennCare enrollees.

MMCC is currently authorized by TDCI and the TennCare Bureau to operate in the community service areas of Shelby County, Northwest Tennessee and Southwest Tennessee which comprise the West Grand Region. All premium revenue earned by MMCC is from payments received for enrollees assigned by the TennCare Bureau. As of June 30, 2005, MMCC reported enrollment of approximately 191,000 TennCare members.

C. Claims Processing Not Performed by MMCC

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy
- Behavioral Health

During the period under examination, MMCC did not subcontract with vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by the TDCI, TennCare Division for the period January 1, 2003 through June 30, 2003:

A. Financial Deficiencies

1. Interest generated from deposit of funds held for provider payments are the property of the state. MMCC did not return interest earned from the deposit of state funds held for provider payments from the beginning of the non-risk period, May 1, 2002, through the examination fieldwork date. MMCC agreed to reimburse the state for previous interest earned and to reduce subsequent claims funding requests for interest earned as required by the CRA. After the completion of examination fieldwork, MMCC refunded the interest earned to the State.

2. During the examination period, third party liability recoveries and subrogation amounts received which were related to the non-risk agreement period were not refunded to the state when recovered. Subsequently, MMCC has refunded to the state third party liability recoveries and subrogation amounts received related to the non-risk agreement period.

3. MMCC incorrectly recorded as cash on the 2003 NAIC Annual Statement a receivable due from the TennCare bureau of $9,684,089. The classification error did not affect MMCC's reported net worth as of June 30, 2003.

4. MMCC incorrectly included in admitted assets $17,095 in receivables from parents, subsidiaries, and affiliates over 90 days old on the June 30, 2003 Quarterly NAIC Statement.

5. MMCC's supplemental TennCare Operations Statement as of June 30, 2003 was not prepared as if MMCC were still operating at risk by including all income and expenses related to claims, losses, and premiums for claims as required by Section 2-10.i. of the CRA.

Findings numbered 1, 2, and 5 above are repeated as part of this report.

B. Claims Processing Deficiencies

1. For 29 of the 60 claims selected for testing, the difference between the date of service and the received date exceeded 120 days. MMCC provider contracts required claims to be submitted within 120 days from the date of service. MMCC did not deny the claims for exceeding timely filing requirements. MMCC indicates the timely filing edit was overridden because the claims were timely received by MMCC's electronic data interface (EDI) claims vendor. Problems occurred with the transmission of the EDI claims from the vendor to MMCC. Providers were allowed to resubmit the claims after the 120 day timely filing limit.

2. For five claims tested where the enrollee has copayment responsibilities, MMCC did not properly accumulate copayments incurred on two claims.

3. MMCC should improve claims inventory control procedures to include a reconciliation that ensures that all claims received, either in the mailroom or electronically, are processed by the claims system or properly returned to the provider.

4. MMCC should improve claims inventory control procedures to ensure that all claims sent to MMCC's vendor for the electronic scanning of claims, Health Solutions Plus, Inc. (HSP), are reconciled to the number of scanned claims returned from the vendor.

5. The following deficiencies were noted during the review of the claims payment accuracy report preparation procedures.

   - Claims were not randomly selected by MMCC from a defined population.

   - The number of claims selected for testing by MMCC was not sufficient to project the results to the entire population.

   - Only paper submitted claims were selected by MMCC for testing. Electronically submitted claims were not tested.

   - MMCC reported 99.3% accuracy for the second quarter 2003; however, when the claims were tested by TDCI and the Comptroller, three claims considered correctly paid by MMCC were incorrectly paid, reducing the accuracy rate to 96%. The CRA requires 97% claims payment accuracy.

   - Additionally, for four correctly paid claims to the same provider, the provider's billed charges equaled the contracted rate. However, it was determined that the fee table logic in the claims system did not correctly reflect the contracted rates. MMCC should review all contracts to ensure the fee table logic in the claims processing system agrees with the contracted rates.

6. MMCC was not in compliance with prompt pay requirement of Tenn. Code Ann. §56-32-226(b) for claims processed during July 2003. Additional testing concluded MMCC had obtained prompt pay compliance for August 2003.

Findings numbered 3, 4, 5, and 6 above are repeated as part of this report.

C. <u>Compliance Deficiencies</u>

1. TDCI and the Comptroller requested MMCC provide any changes to reimbursement rates and policies since April 16, 2002. MMCC provided correspondence to the TennCare Bureau requesting approval for changes

to reimbursement rates. For two of eleven requests for changes to reimbursement rates, a corresponding TennCare Bureau approval was never provided. MMCC contends that for the unapproved changes to the reimbursement rates, the resulting changes were cost beneficial to the TennCare Program.

2. For the 12 provider complaints selected for testing, MMCC did not properly respond to three complaints.

3. Three provider agreements selected for testing did not contain all provisions required by Section 2-18. of the CRA.

4. MMCC lacks an internal audit function as part of MMCC's organizational structure.

Findings numbered 3 and 4 are repeated as part of this report.

V. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The detail of testing as well as management comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiencies

1. MMCC did not report as short term investments bonds which mature in less than one year as required by Statutory Accounting Principle No.2. (See Section VI.A.4.)

2. MMCC improperly increased revenue and expenses by the same amount on the NAIC financial statements for the MedCall cost center. (See Section VI.A.5.)

3. On the NAIC financial statements, the write-in for provider advances totaling $97,000 were correctly non-admitted but should be reclassified as a healthcare receivable. (See Section VI.A.6)

4. MMCC did not prepare the TennCare Operations Statement as if MMCC were still at risk, because it did not include reimbursements for premium taxes in either revenue or expenses as required by Section 2-10.i. of the CRA. (See Section VI.B.)

B. Claims Processing Deficiencies

1. MMCC was not in compliance with prompt pay requirements of Tenn. Code Ann. §56-32-226(b) for claims processed during February 2005. (See Section VII.A.)

2. The following deficiencies were noted during the review of the claims payment accuracy reports.

   - As reported in the prior examination findings, the number of claims selected for testing by MMCC was not sufficient to project the results to the entire population. Only 99 claims are tested each quarter in preparation of the claims payment accuracy reports.

   - As evidenced by the third quarter 2005 report submitted, MMCC has not initiated requirement of Section 2-9.g. of the CRA effective July 1, 2005. The report was not prepared by an internal auditor. The CRA requires, at a minimum, that 100 claims be tested monthly. MMCC's third quarter report indicates only 99 claims were tested for the quarter.

   (See Section VII.C.2)

3. TDCI was unable to confirm the contracted rate for one claim because MMCC was unable to locate the provider agreement. (See Section VII.G.)

4. MMCC does not maintain a log of rejected claims returned to providers. Without this log**,** MMCC will be unable to ensure that all claims received in the mailroom have either been processed through the system or returned to the provider. (See Section VII.M.)

5. For two of fourteen claims tested from the mailroom, the receipt date in the claims processing system was different from the actual date the claim was received. (See Section VII.M.)

C. Compliance Deficiencies

1. Two of three provider agreements selected for testing did not contain all provisions required by Section 2-18. of the CRA. (See Section VIII.C.)

2. Capitation payments for a quarter resulted in an over payment to one provider for approximately $302,000. (See Section VIII.D)

3. MMCC lacks an internal audit department. Per Section 2-9.a.14. of the CRA effective July 1, 2005, MMCC is required to have in place the internal audit function, and specifically Section 2-9.g. requires that internal audit should be performing the claims payment accuracy testing beginning with the Third Quarter 2005 reporting due on October 30, 2005. (See Section VIII.G.)

4. Interest earned for May through June 2005 was not returned to the State in a timely manner per Section 3-10.h.2.(d). of the CRA. (See Section VIII.J.4)

5. Subrogation amounts collected for April through June 2005 were not returned to the State in a timely manner per Section 3.-10.h.2.(f) and (g) of the CRA. (See Section VIII.J.5.)

6. MMCC should establish an internal audit department to enhance compliance efforts with the conflict of interest clause of the CRA. Additionally, the organizational chart should indicate the compliance officer should report to the Board of Directors (See Section VIII.K.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, MMCC is required to file annual and quarterly NAIC financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if MMCC meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At June 30, 2005, MMCC reported $28,240,645 in admitted assets, $2,484,458 in liabilities and $25,756,184 in capital and surplus on its NAIC quarterly statement. MMCC reported total net income of $4,838,917 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires MMCC to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

2005 Statutory Net Worth Calculation

MMCC's premium revenue per documentation obtained from the TennCare Bureau totaled $380,952,365 for the calendar year 2004; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), MMCC's statutory net worth requirement for the calendar year 2005 is $9,464,285. MMCC reported total capital and surplus of $25,756,184 as of June 30, 2005, which is $16,291,899 in excess of the minimum statutory net worth requirement.

Premium Revenue for the Examination Period

For the examination period January 1 through June 30, 2005, the following is a summary of MMCC's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2):

Administrative fee payments from TennCare for the period January 1 through June 30, 2005	$14,858,640
Reimbursement for medical payments from TennCare for the period January 1 through June 30, 2005	173,581,674

Reimbursement for premium tax payments from TennCare for the period January 1 through June 30, 2005	3,793,464
Total premium revenue	$192,233,778

2. Restricted Deposit

Tenn. Code Ann. § 56-32-212(b)(2) and (3) requires all HMOs licensed in the state to maintain a deposit equal to $900,000, plus an additional $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal wavier received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..."

Based upon premium revenues for calendar year 2004 totaling $380,952,365, MMCC's statutory deposit requirement at June 30, 2005, is $3,150,000. MMCC had on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $3,200,000 had been pledged for the protection of the enrollees in the State of Tennessee. Subsequently, an amendment to the CRA as of July 1, 2005, changed the deposit requirements to equal the calculated statutory net worth. MMCC increased the deposits pledged for the protection of the enrollees in the State of Tennessee to $9,700,000 to comply with the CRA.

3. Claims Payable

As of June 30, 2005, MMCC reported no claims unpaid on the NAIC quarterly statement. This amount represented an estimate of unpaid claims or incurred but not reported (IBNR) for only the "at risk" period ending April 30, 2002. Review of the triangle lag payment report after June 30, 2005, through August 31, 2005, for dates of services before May 1, 2002 determined that the reported claims payable appears reasonable.

4. Classification of Investments

   Per NAIC guidelines, investments in bonds maturing in one year or less from the acquisition date should be reported as short-term investments.

   MMCC did not report as short-term investments bonds which mature in less than one year as required by Statutory Accounting Principle No. 2. The reclassification of bonds to short-term investments will not affect net income or net worth.

   Management's Comments

   MMCC Management concurs.

5. Accounting for MedCall Allocation

   In an attempt to recognize the value of services provided to TennCare enrollees by MedCall, MMCC overstated revenue and expenses by $161,417 on the NAIC financial reports. MedCall is a component of MMCC's general ledger accounts. MedCall is a call center which provides services to MMCC's TennCare enrollees as well as to external organizations. General ledger accounts already capture the actual direct costs incurred for MedCall such as salaries and benefits paid to employees. The entry to eliminate MedCall's other revenue of $161,147 and associated expenses of $161,147 will not affect net income or net worth.

   Management's Comments

   MMCC Management concurs.

6. Advances to Providers

   MMCC reported a $97,000 receivable for advances to providers as a write-in for other than invested assets, MMCC correctly non-admitted the receivable since it was over 90 days old. MMCC should report this asset as a health care receivable. The reclassification of the health care receivable will not affect net income or net worth.

   Management's Comments

   MMCC Management concurs.

B. Administrative Services Only (ASO)

As previously mentioned, effective May 1, 2002, MMCC's CRA was amended so that MMCC would operate as an ASO until December 31, 2003. The stabilization period has been extended until December 31, 2006.

These types of arrangements are considered "administrative services only" (ASO) by the NAIC. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected in the balance sheet for MMCC for dates of service after April 30, 2002.

The CRA requires a deviation from ASO reporting guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if MMCC were still operating at-risk. As stated in section 2-10.i. of the CRA, MMCC is to provide "an income statement addressing the TennCare operations." TennCare HMOs provide this information on the Report 2A.

MMCC did not prepare the TennCare Operations Statement as if MMCC were still at risk, because it did not include reimbursements for premium taxes in either revenue or expenses. Section 2-10.i. of the CRA requires all income and expenses related to claims, losses, and premiums for claims with dates of service after May 1, 2002, to be included in the TennCare Operations Statement. The deficiencies in preparing Report 2A did not affect MMCC's reported net worth or net income; however, Report 2A should present MMCC's operations as if MMCC were still at risk.

Management's Comments

MMCC Management concurs.

C. Medical Fund Target

Effective July 1, 2002, the CRA requires MMCC to submit a Medical Fund Target (MFT) on a monthly basis. The MFT accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred

but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT. MMCC submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for IBNR expenses have been reviewed for accuracy. No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Fund Target report.

D. Schedule of Examination Adjustments to Capital and Surplus

There were no adjustments to capital and surplus as a result of the examination.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1) and Section 2-18. of the CRA. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either

> that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-226(b)(1) by testing in three-month increments quarterly data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. If a TennCare MCO fails to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, requires claims data submissions on a monthly basis for the next three months to ensure the MCO remains complaint.

The prompt pay testing results for the examination period are as follows.

	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2005	99%	99.8%	**Yes**
February 2005	99%	99.2%	**No**
March 2005	100%	99.9%	**Yes**
April 2005	100%	100.0%	**Yes**
May 2005	100%	100.0%	**Yes**
June 2005	99%	99.9%	**Yes**

MMCC processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for claims processing requirements for the month of January 2005, and March through June 2005. However, MMCC did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the month of February 2005.

Management's Comments

MMCC Management concurs. MMCC Management would like to point out that although claims process timelines requirements were not met in

February of 2005, MMCC has consistently and significantly exceeded requirements thereafter.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of testing performed on MMCC's claims processing system.

The following items were reviewed to determine the risk that MMCC had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints or independent reviews on file with TDCI related to accurate claims processing
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims processing accuracy reports
- Review of internal controls.

As noted below, TDCI discovered deficiencies related to MMCC's procedures for preparing the claims payment accuracy reports. However, the deficiencies did not result in an increase in TDCI's and Comptroller's substantive testing.

C. Claims Payment Accuracy Report

Section 2-9. of the CRA requires that 97% of claims are paid accurately upon initial submission. MMCC is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

MMCC reported the following results for the first and second quarters of 2005:

	Results Reported	Compliance
First Quarter 2005	99.1%	**Yes**
Second Quarter 2005	99.4%	**Yes**

1. Procedures to Review the Claims Payment Accuracy Reporting

The review of the claims processing accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment

accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the second quarter 2005 claims payment accuracy report. In addition 20 claims were selected at random by TDCI and the Comptroller from MMCC's second quarter claims payment accuracy report for review. This review included verification that the number of claims selected by MMCC constituted an adequate sample to represent the population. The selected claims were reviewed to determine that the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation were traced directly to the actual report filed with TennCare. Also, all claims identified in the report with errors were reviewed to ensure the errors have been corrected. Further, TDCI reviewed MMCC's third quarter 2005 Claims Payments Accuracy Report to determine if MMCC had incorporated the changes required as a result of the CRA effective July 1, 2005.

2. Results of Review of the Claims Payment Accuracy Reporting

The following deficiencies were noted during the review of the claims payment accuracy reports.

- As reported in the prior examination findings, the number of claims selected for testing by MMCC was not sufficient to project the results to the entire population. Only 99 claims are tested each quarter in preparation of the claims payment accuracy reports.

- As evidenced by the third quarter 2005 report submitted, MMCC has not implemented the requirements of Section 2-9.g. of the CRA effective July 1, 2005. The report was not prepared by an internal auditor. The CRA requires, at a minimum, that 100 claims be tested monthly. MMCC's third quarter report indicates only 99 claims were tested for the quarter.

Management's Comments

MMCC Management concurs. MMCC has taken the necessary steps to correct such deficiencies. MMCC Management would like to further add that MMCC had actually audited over a 1000 claims per month for internal audit purposes but we only reported 99 claims per month.

D. Claims Selected For Testing From Prompt Pay Data Files

Sixty additional claims were selected from the April 2005 prompt pay data files previously submitted to TDCI. For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by MMCC.

To ensure that the April 2005 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in MMCC's claims processing system. Attachment XII of the CRA lists the minimum required data elements to be recorded from medical claims and submitted to TennCare as encounter data. Original hard copy claims were requested for the 60 claims tested. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested.

The data elements recorded on the claims were compared to the data elements entered into MMCC's claims processing system. No discrepancies were noted between the information submitted on the claims and the data recorded in MMCC's system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected.

For the 60 claims selected for testing, no discrepancies were noted.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to

providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

From the 60 claims selected for testing, the paid amount for ten claims was compared to amounts required by the provider's contract. TDCI was unable to confirm the contracted rate for one claim because MMCC was unable to locate the provider agreement. MMCC indicated that the provider contract had been reissued and was out to the provider for signature.

Management's Comments

MMCC Management concurs. MMCC Management would like to point out that 9 of the 10 claims selected for comparison between the paid amounts and the amounts required by the provider's contract were correctly paid. As for the provider contract (Purihin Clinic, PC) that was out for signature, it is now back in the MMCC office.

H. Copayment Testing

The purpose of testing copayment is to determine if enrollees are subject to out-of-pocket payments for certain procedures, if out-of-pocket payments are within liability limitations, and if out-of-pocket payments are accurately calculated in accordance with Section 2-3.i. of the CRA.

Five enrollees with copayment responsibilities were selected for testing. No discrepancies were noted.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

The examiners requested remittance advices for ten of the 60 claims selected for testing to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the related information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by MMCC; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for the ten claims which were also selected for remittance advice testing. Cancelled checks were provided by MMCC. The check amounts agreed with the amounts paid per the remittance advice and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

The July 31, 2005 pend file was selected for testing. Review of the pended claims does not indicate that MMCC has a significant number of claims exceeding 60 days. No material liability exists for claims over 60 days.

L. Electronic Claims Capability

Section 2-9.g. of the CRA states, “The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment ….” The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

MMCC has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes.

M. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures by MMCC ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system.

Certain claims submitted by providers must be rejected due to provider error. These claims are sent back to the provider with a form letter noting the reason the claim could not be accepted. MMCC does not maintain a log of rejected claims returned to providers. Without this log**,** MMCC will be unable to ensure that all claims received in the mailroom have either been processed through the system or returned to the provider. MMCC demonstrated a claims inventory system in development to account for rejected claims. The system was not effective as of the end of fieldwork but when the system becomes operational, it should account for all claims received in the mailroom and electronically.

Management's Comments

MMCC has implemented a logging and tracking mechanism to account for and keep record of all claims returned to the provider that have been received via the MMCC mailroom.

In addition, the Claims Inventory Tracking System demonstrated previously is now in place and partially operational. The Inventory Tracking System will be fully operational by the 2nd Quarter of 2006.

Fourteen claims were judgmentally selected from a batch of incoming mail on September 28, 2005.

- Four claims were submitted by non-participating providers and were returned to the providers because the providers were not credentialed.
- Eight claims were processed with a receipt date of September 28, 2005.
- Two claims were processed with the receipt date of October 17, 2005. These claims were entered into the claims processing system 19 days after the actual receipt date.

Management's Comments

MMCC concurs with the findings. Of the 14 claims selected for review, 12 were handled properly and correctly processed. The two claims identified with a later than actual received date were the result of an error during the transforming of the hard copy data into electronic EDI form. Safeguards have been put in place to prohibit this error from occurring on any future claims submissions.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

Provider complaints were tested to determine if MMCC properly responded to all provider complaints in a timely manner. MMCC's written policies and procedures require MMCC to respond within 30 days. MMCC utilizes a customer service report to log all provider complaints. Fifteen complaints were selected for testing from MMCC's customer service report. MMCC properly responded to 15 provider complaints within 30 days. No other deficiencies were noted.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. MMCC submitted the provider manual and TDCI approved the manual on January 5, 2005.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to: standards of care, assurance of TennCare enrollees rights, compliance with all federal and state laws and

regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the CRA between MMCC and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the CRA requires that all provider agreements executed by MMCC shall at a minimum meet the 44 current requirements listed in Section 2-18.

Three provider contracts were reviewed to determine compliance with Section 2-18. of the CRA. The provider contracts represented the following provider types: hospital and specialty. The hospital agreement was found to be in compliance with Section 2-18. of the CRA.

Some or all of the following required provider language of Section 2.18 of the CRA were not found in the two specialty contracts selected for testing:

f. Specify that the provider may not refuse to provide medically necessary or covered preventive services to a TennCare patient under this Agreement for non-medical reasons, including, but not limited to, failure to pay applicable TennCare cost sharing responsibilities. Upon next renewal of provider agreements, the CONTRACTOR shall specify that effective January 1, 2003, the CONTRACTOR may require that a TennCare Standard enrollee pay applicable TennCare cost share responsibilities prior to receiving non-emergency services. However, until such time that an amendment to the provider agreements are executed, the CONTRACTOR shall include said provisions in the providers administrative manual or other such communications. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

gg. Specify the extent to which any savings or loss realized by the plan shall be shared with the providers;

mm. Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the MCO, such requirement shall be

null and void and all other provisions shall remain in full force and effect;

pp. Specify that in the event that TENNCARE deems the MCO unable to timely process and reimburse claims and requires the MCO to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the MCO's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;

ss Specify instruction that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency.

tt. Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR, Part 455, Subpart B.

Management's Comments

MMCC Management concurs as to the findings relating to provider agreement requirements for the selected contracts.

D. Provider Payments

Examiners tested capitation payments to providers during June 2005 to determine if MMCC had complied with the payment provisions set forth in its provider agreements.

Four capitated provider payments were tested for timeliness and accuracy. For one provider tested, capitation payments for a quarter resulted in an overpayment of approximately $302,000. The provider contract requires that thirty days following the close of each calendar quarter, MMCC and the provider shall reconcile the amount of gross charges incurred in such calendar quarter. The reconciliation payment for the first, second, and third quarter of 2004 was made on July 1, 2005 and, thus, was not made timely. MMCC responded that the next capitation payment to the provider will be reduced by the amount of the overpayment. If the overpayment was recouped on the next capitation payment, the funding request to the TennCare Bureau will also be reduced by the overpayment.

Management's Comment

MMCC Management concurs as to the overpayment of $302,000 to Pediatric Emergency Specialists as related to the testing of the capitated provider payments for timeliness and accuracy. This overpayment amount was fully recouped and returned to the State.

E. Subcontracts

HMOs are required to file a notice and obtain the commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). MMCC submitted for approval the subcontract to AlphaMaxx for case management services.

F. Non-discrimination Compliance Testing

Section 2-24 of the CRA requires MMCC to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various MMCC staff and a review of policies and related supporting documentation, MMCC was in compliance with the reporting requirements of Section 2-24 of the CRA.

G. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

As noted in the prior examination, MMCC lacks an internal audit department. MMCC had not corrected this finding as of the end of fieldwork. MMCC responded that it is in the process of filling the internal audit position. Per Section 2-9.a.14. of the CRA effective July 1, 2005 MMCC is required to have in place the internal audit function and specifically Section 2-9.g. requires that internal audit should be performing the claims payment accuracy testing beginning with the Third Quarter 2005 reporting due on

October 30, 2005. Additionally, the internal audit department should schedule and perform focused reviews of compliance with the CRA requirements including the determination of compliance with conflict of interest.

Management's Comments

MMCC Management generally concurs with the statements regarding the establishment of an internal audit function within the MMCC organization, although several additional facts should be considered. The Contractor Risk Agreement (CRA) was not signed and returned by the State until August of 2005. The establishment of an internal audit function, reporting to the finance committee chairman, was approved by the Board of Directors through its finance committee in August of 2005. Because of the resignation of the Chief Financial Officer, who would have been principally responsible for conducting the interview process for the internal auditor position, the process of recruitment was delayed. During the interim, a new automated claims audit selection product has been installed and is in use. The process of installing the claims selection tool was jointly coordinated by the new Chief Financial Officer and the Claims Department Manager.

A new controls assurance division has been established by MMCC and approved by the MMCC Board of Directors. This new division includes the Internal Audit and Compliance functions. The Internal Auditor position has been recruited/filled and employed by the new Chief Financial Officer, and has begun job duties in February of 2006. Per the recommendations of the State, the claims auditors report to the Internal Auditor position. Both the Internal Auditor position (Internal Audit Manager) and the Compliance Officer will be a part of the Control Assurance division at Memphis Managed Care Corporation, and both will functionally report to the Board of Directors through the Chairman of the Finance Committee.

H. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." MMCC has complied with this statute.

I. Behavioral Health Organization (BHO) Coordination

MMCC was in compliance with Section 2-3.c.2 of the CRA whereby effective July 1, 2002, "claims for covered services with a primary behavioral diagnosis code, defined as ICD 9-CM 290.xx- 319.xx'' are submitted to MMCC for timely processing and payment.

MMCC is required to refer unresolved disputes between the HMO and BHO to the State for a decision on responsibility after providing medically necessary services. MMCC did not have any ongoing disputes with the BHO.

J. Contractual Requirements for ASO Arrangements

As previously mentioned, effective May 1, 2002, MMCC's CRA was amended so that MMCC would operate as an ASO. As a result, the provisions tested below are a requirement for transactions with dates of service after May 1, 2002.

1. Medical Management Policies

Section 2-2.s. of the CRA requires MMCC to comply with the following as it relates to the TennCare line of business:

> Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as that existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002, to the State for purpose of documenting medical management policies and procedures before final execution of this Amendment.

MMCC's management has confirmed compliance with the requirements described above. During testing of claims processing and provider contracts, no deviations to the requirement were noted.

2. Provider Payments

Section 3.10.h.2(b) of the CRA states that MMCC "shall release payments to providers within 24 hours of receipt of funds from the State." The check run issued on October 10, 2005 was selected for testing. Based on TDCI's review, MMCC has complied with this provision.

3. 1099 Preparation

   Section 3-10.h.2(c) of the CRA states that MMCC "shall prepare and submit 1099 Internal Service Reports for all providers to whom payment is made." Based on TDCI's review, MMCC has complied with this requirement.

4. Interest Earned on State Funds

   Section 3-10.h.2.(d) of the CRA states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. The interest amount earned on the funds reported on MMCC's monthly bank statement should be deducted from the amount of the next remittance request from the TennCare Bureau.

   Interest earned for May through June 2005 was not returned to the State in a timely manner per Section 3-10.h.2.(d). of the CRA because they were not reduced from the next reimbursement request to the TennCare Bureau as they were earned.

   Management's Comments

   MMCC Management concurs. MMCC has taken the necessary steps to correct such deficiencies.

5. Recovery Amounts/Third Party Liability

   Section 3-10.h.2.(f) and (g) of the CRA require third party liability recoveries and subrogation amounts related to the non-risk agreement period be reduced from medical reimbursement requests of the TennCare Bureau. As third party liability and subrogation amounts are recovered, MMCC should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered.

   Subrogation amounts collected for April through June 2005 were not returned to the State in a timely manner per Section 3.-10.h.2.(f) and (g) of the CRA because they were not reduced from the next reimbursement request to the TennCare Bureau as they were recovered.

Management's Comments

MMCC Management concurs. MMCC has taken the necessary steps to correct such deficiencies.

6. Pharmacy Rebates

Section 3-10.h.2.(f) of the CRA states that pharmacy rebates collected by MMCC shall be the property of the State. During the on-site visit, MMCC indicated no further amounts were expected from the PBM for services which ended June 30, 2003.

K. Conflict of Interest

Section 4-7. of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to MMCC in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Subsequent to the examination period, conflict of interest requirements of the CRA were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with the provisions required by the CRA shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of CRA conflict of interest clauses in all agreements, subcontracts, provider agreements, and any and all agreements that result from the CRA.

MMCC demonstrated the following efforts to ensure compliance with conflict of interest clause of the CRA:

- The most recently approved provider agreements contain the conflict of interest language of the CRA.

- The organizational structure of MMCC includes a compliance officer who reports to the CFO.

- MMCC has written conflict of interest policies and procedures in place.

- The written policies and procedures outline steps to report violations.

- The policy indicates all business associates are to comply with MMCC's conflict policy.

- Employees complete conflict of interest certificates of compliance annually per the written policy and procedures. The certificates were last completed in April 2005.

As previously mentioned, effective May 1, 2002, the CRA with MMCC was amended for MMCC to temporarily operate under a non-risk agreement. MMCC agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau. Before April 16, 2002, MMCC held a reinsurance policy with Oseman Insurance Agency. MMCC was required to maintain this policy during stabilization. The reinsurance premiums are funded by TennCare and recoveries from this policy were reimbursed to TennCare. In 2005, MMCC became aware that a former State Senator was an insurance agent for Oseman Insurance Agency. On April 21, 2005, MMCC requested approval from the TennCare Bureau to eliminate the policy and seek bids for another reinsurance policy effective July 1, 2005. On June 17, 2005, the TennCare Bureau requested any MCO with reinsurance policies to terminate such policies by July 31, 2005. MMCC cancelled the reinsurance policy accordingly.

In addition to efforts by MMCC to ensure compliance with conflict of interest clause of the CRA discussed above, TDCI recommends the following:

- MMCC should establish an internal audit department. The internal audit department should schedule and perform focused reviews of compliance with the CRA requirements including the determination of compliance with conflict of interest. MMCC’s current contract with the TennCare Bureau requires MMCC to appoint specific staff to an internal audit department which shall report directly to the board of directors or other such

appropriate level of management. MMCC is required to submit an annual Audit Plan to TennCare.

- The organizational chart should indicate that the compliance officer should report to the Board of Directors.

Management's Comments

MMCC Management generally concurs with the statements regarding the establishment of an internal audit function within the MMCC organization, although several additional facts should be considered. The Contractor Risk Agreement (CRA) was not signed and returned by the State until August of 2005. The establishment of an internal audit function, reporting to the finance committee chairman, was approved by the Board of Directors through its finance committee in August of 2005. Because of the resignation of the Chief Financial Officer, who would have been principally responsible for conducting the interview process for the internal auditor position, the process of recruitment was delayed. During the interim, a new automated claims audit selection product has been installed and is in use. The process of installing the claims selection tool was jointly coordinated by the new Chief Financial Officer and the Claims Department Manager.

A new controls assurance division has been established by MMCC and approved by the MMCC Board of Directors. This new division includes the Internal Audit and Compliance functions. The Internal Auditor position has been recruited/filled and employed by the new Chief Financial Officer, and has begun job duties in February of 2006. Per the recommendations of the State, the claims auditors report to the Internal Auditor position. Both the Internal Auditor position (Internal Audit Manager) and the Compliance Officer will be a part of the Control Assurance division at Memphis Managed Care Corporation, and both will functionally report to the Board of Directors through the Chairman of the Finance Committee.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of MMCC.